TRICARE Fundamentals Course

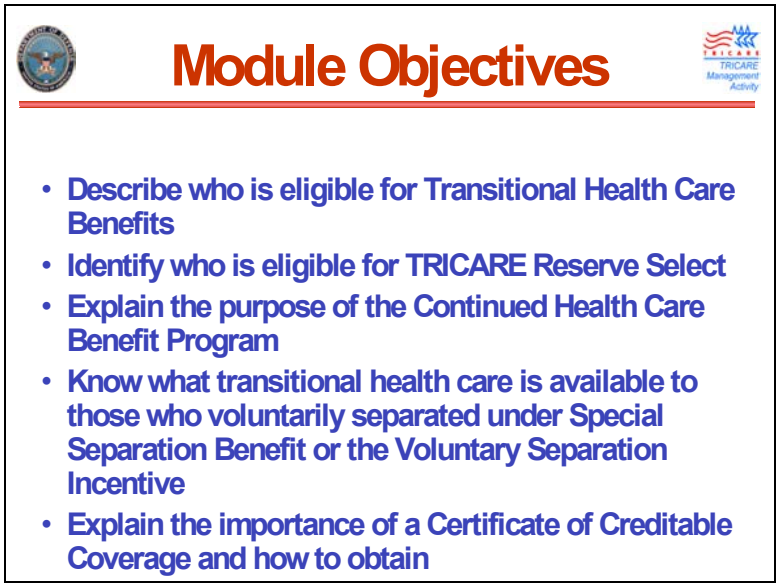
Module 7

Transitional Benefits

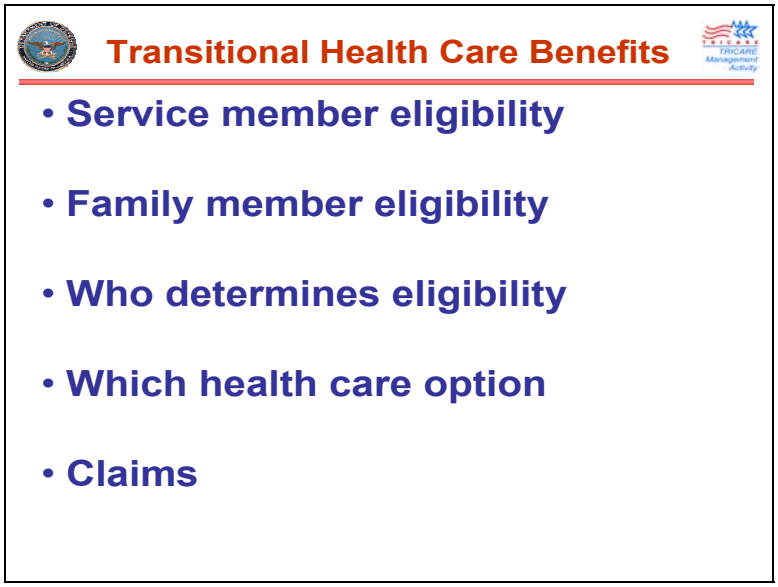
Participant Guide

References
10 U.S.C.
32 C.F.R. § 199.20
Public Law 102-484
National Defense Authorization Act, FY 1993
TRICARE Policy Manual 6010.47-M

Module Objectives



Transitional Health Care Benefits for Service Members



Transitional health care benefits are available in the Military Health System (MHS) for uniformed services members (and their eligible family members).

Transitional Assistance Management Program (TAMP)

- The Transitional Assistance Management Program establishes TRICARE eligibility for specific categories of beneficiaries.
  - The sponsors and their family members are eligible for continued TRICARE medical benefits including enrollment or re-enrollment in TRICARE Prime services and supplies provided under the Extended Care Health Option (ECHO), and MTF care, for a defined period of time as indicated in the Defense Enrollment Eligibility Reporting System (DEERS).
  - While the status of these individuals is neither active duty nor retiree or deceased, for the purpose of cost sharing, the claims for these individuals (including former active duty members) shall be processed as active duty dependents.

Service Members

- The uniformed services member eligibility categories include the following:
  - A member who is involuntarily separating from active duty under honorable conditions
  - A Reserve component (RC) member (which includes certain members of the National Guard) separating from an active duty period of more than 30 consecutive days in support of a contingency operation
  - A member separating from active duty following involuntary retention (Stop-Loss) in support of a contingency operation
  - A member separated from active duty following a voluntary agreement to stay on active duty for less than 1 year in support of a contingency operation

- If the Service member served and is due transitional health care benefits, the Service member will receive a total of 180 days of benefits.
- Service members and family members must be accurately reflected in the Defense Enrollment Eligibility Reporting System (DEERS).
  - Members need to validate self and family information in DEERS before separation.
  - Members need to update their information, if applicable, during the transition (i.e., if the sponsor and family move, they need to update addresses in DEERS).
  - RC members need to ensure the contingency operation is correctly coded in DEERS.

Family Members

- Family members of eligible Service members who separated on or after January 1, 2002, are eligible for transitional health care benefits.
  - Family members have the same level of transitional health care benefits as their sponsor.
    - Except dental benefits, which are available under the separate TRICARE Dental Program, if eligible
  - Eligible family members receive the TRICARE benefit for the same 180 days after the Service member's separation date as the sponsor.

Who Determines Eligibility?

- Each Service branch determines eligibility for transitional health care benefits.
  - The Service branches are Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, or the National Oceanic & Atmospheric Administration.
  - Active duty and Reserve component service members who are separating from active duty and need to verify their eligibility for transitional health care benefits for themselves and their family members
  - Service members are encouraged to contact their nearest Service personnel office for assistance.
- The Service personnel representative determining eligibility provides eligibility information to DEERS.

Which Health Care Option?

- TRICARE Prime (enrolled prior to release from active duty)
  - Those members and their family members who were enrolled in TRICARE Prime while on active duty will be automatically disenrolled upon the member's release from active duty.
  - Members must actively reenroll themselves and family members if they wish to continue with this option during the transitional period.
  - No waiting period will be imposed, but members must complete and submit a TRICARE Prime enrollment application for themselves and eligible family members prior to or upon release from active duty. If not, they will continue coverage under TRICARE Standard or TRICARE Extra.

- TRICARE Prime (not enrolled at the time of release from active duty)
  - Those members and their family members who were not enrolled in TRICARE Prime before the member's release from active duty may enroll in TRICARE Prime during the transitional health care period.
  - Enrollment for members and their families is subject to the "20th of the month" enrollment rule.
    - Those who enroll on or before the 20th of the month will not be eligible for health care benefits under TRICARE Prime until the first day of the month following the month of enrollment.
    - Those who enroll after the 20th of the month will not be eligible for care until the first day of the second month following the month of enrollment.
    - Example: a member enrolling on January 25th becomes eligible for TRICARE Prime on March 1st.
- TRICARE Standard or TRICARE Extra
  - No enrollment required.
  - Members and the family members may submit claims for care from a TRICARE-authorized provider to the TRICARE regional contractor.

Medical Hold Personnel

- The Services are responsible for managing the care of their members on medical hold.
  - This may involve the processing of referrals and authorizations under the TRICARE benefit program.

Claims

Claims for eligible members and their families are processed the same as those for active duty family members.

TRICARE Reserve Select

A new TRICARE benefit has been implemented that is designed to help certain members of the Reserve Component after release from active duty. TRICARE Reserve Select is the premium-based TRICARE health plan offered for purchase to certain National Guard and Reserve members (also referred to as Reserve component members) who have been activated in support of a contingency operation since September 11, 2001 and who meet certain eligibility conditions. It can be used to extend the member's health care benefits beyond the standard Transitional Assistance Management Program (TAMP) benefits.

Selected Reserve Service Agreement

- To establish eligibility for TRICARE Reserve Select, the Reserve Component member must enter into a Service Agreement with their Reserve component to stay in the Selected Reserve for one or more whole years.

  - *Note:* Just signing the Service Agreement does not guarantee a Selected Reserve billet. Reserve component members must work with their Service/Reserve component after leaving active duty to execute the agreement (be in the Selected Reserve) by the time their TRS coverage begins. When the agreement has been executed, the member becomes eligible to purchase TRS.

  - For members separated from qualifying active duty service on or before April 26, 2005, they must execute a Service Agreement by October 28, 2005.

  - For members who separate from qualifying active duty service on or after April 27, 2005, they must execute a Service Agreement within four months after leaving active duty.

Eligibility

Eligibility to purchase TRICARE Reserve Select is established with the personnel offices of the member's Service/Reserve component. Reserve component members may be eligible to purchase TRICARE Reserve Select for themselves and their family members if they meet the following conditions.

1. Were called or ordered to active duty under Title 10 in support of a contingency operation for more than 30 consecutive days on or after September 11, 2001.

2. Served continuously on active duty for 90 days or more under such call or order—the length of time served determines the maximum period of coverage offered under TRICARE Reserve Select.

- *Note:* If the National Guard/Reserve member is otherwise eligible, but did not serve continuously on active duty for 90 days under such call or order due to an injury, illness, or disease incurred or aggravated while they were activated, the member may be eligible for one year of TRICARE Reserve Select coverage.

3. Entered an agreement to serve in the Selected Reserve.

- All Reserve component members who separated from qualifying active duty service must work with their Service/Reserve component to execute the Service Agreement.

- For members separated from qualifying active duty service on or before April 26, 2005, they must execute their Service Agreement by October 28, 2005.
  - If members have not executed a Service Agreement by October 28, 2005, members give up the opportunity to purchase TRICARE Reserve Select coverage.

- For members who separate from qualifying active duty service on or after April 27, 2005:
  - They must enter into a Service Agreement prior to leaving active duty through the Guard-Reserve Portal at: www.dmdc.osd.mil/Guard-ReservePortal from any Web browser.
    - If they do not enter into a Service Agreement before separation, they give up their opportunity to purchase TRICARE Reserve Select coverage for their period of active duty.
    - *Note:* Entering into a Service Agreement does not guarantee a Selected Reserve billet.
  - And they must contact their Service/Reserve component within four months after leaving active duty to execute their Service Agreement.

Enrollment

Once a Reserve Component member executes the Service Agreement, the Service/Reserve component will record eligibility in DEERS allowing the Reserve component member to purchase TRICARE Reserve Select.

Upon the DEERS update, the Reserve component member will have access to the TRICARE Reserve Select enrollment form available for download on the Guard-Reserve Portal at www.dmdc.osd.mil/Guard-ReservePortal.

The Reserve component member should print their personalized enrollment form from the Guard-Reserve Portal. Then the Reserve component member should follow the instructions on their TRICARE Reserve Select enrollment form, complete the form, choose what type of coverage they want to purchase, and submit it with a one-month premium payment to their TRICARE regional contractor so they receive it no later than 30 days before the end of TAMP. This will ensure there is no interruption in their health care coverage.

Type of Coverage

- When Reserve component members complete their TRICARE Reserve Select (TRS) enrollment form, they must select one of the types of coverage:
  - TRS member-only coverage, or
  - TRS member and family coverage

Changing the Type of Coverage

Members can change the type of coverage after their TRICARE Reserve Select coverage begins only if they have a qualifying life event:

- A change in family composition (e.g., birth of a child, marriage or divorce of the member, loss of eligibility, etc.)
- When there is an event affecting family health coverage (e.g., employment change)

Note: There is no open season for any type of coverage changes at any time.

Coverage Provided

TRICARE Reserve Select offers comprehensive health coverage similar to TRICARE Standard and TRICARE Extra. TRS coverage includes:

- Urgent and emergency care including ambulance services
- Family health care
- Obstetrics, gynecology, and maternity services
- Clinical preventive services including health screening and immunizations
- Behavioral health care including partial hospitalization and residential treatment
- Annual eye examinations
- Durable medical equipment (DME) and supplies
- Ancillary services such as laboratory and radiology
- Prescription drug coverage

The beneficiary has access to care from any TRICARE authorized provider, hospital, or pharmacy—TRICARE network or non-network from the day their coverage begins.

Covered members may access care from a military treatment facility (MTF) on a space-available basis only.

Pharmacy Coverage

- Pharmacy coverage is available from the:
  - TRICARE Mail Order Pharmacy (TMOP)
  - TRICARE Network Retail Pharmacies
  - Non-network Retail Pharmacies
  - MTF pharmacies

Period of Coverage

The National Guard or Reserve member may be eligible for one whole year of TRICARE Reserve Select coverage for each whole year of service commitment in the executed Service Agreement, up to a maximum of one whole year of coverage for each 90 days of continuous active duty served in support of a contingency operation.

The table below shows possible periods of coverage

Days Served on Active Duty	**Maximum Period of Coverage**	**Service Agreement**
1-89 days	None*	NA
90-179 days	1 year	1 or more years
180-269 days	2 years	2 or more years
270-359 days	3 years	3 or more years
360-449 days	4 years	4 or more years
* Reserve component members who are otherwise eligible, but did not serve continuously on active duty for 90 days solely because of an injury, illness or disease incurred or aggravated while activated, may be eligible for one whole year of TRICARE Reserve Select coverage.		

For example, a Reserve component member who served one year in support of a contingency operation may qualify for four years of coverage if the Service Agreement is for four whole years.

However, if the Service Agreement is for only two years, TRICARE Reserve Select will be for only two whole years of coverage.

This two-year coverage period *cannot* be extended, even with an extension of Selected Reserve service for two more years.

Overseas

TRICARE Reserve Select is available outside the 50 United States. The TRICARE South region contractor will handle enrollment, billing, and customer support services for these areas. TRICARE Area Offices overseas can provide information about accessing health care in overseas locations.

Premium Billing and Payment

The monthly premiums for calendar year 2005 are:
- $ 75.00 for TRS member-only coverage
- $233.00 for TRS member and family coverage

Monthly premiums are required for TRICARE Reserve Select coverage and are adjusted effective January 1st each year. The most up to date premiums can be reviewed at www.tricare.osd.mil/reserveselect.

Initial premium payments, submitted with the completed TRICARE Reserve Select enrollment form equal to one-month's premium for the type of coverage selected, may be paid by:
- Check, money order, or cashier's check payable to the appropriate TRICARE regional contractor, or
- Visa®/MasterCard® (specify card number, expiration date, and cardholder's signature).

After the initial payment (included with the enrollment form), the servicing TRICARE regional contractor will send a bill by the 10th day of each month and the payment is due no later than the 30th day of each month.

Premium payments are due in advance and will apply to coverage for the following month of coverage. The bill will specify how to change the method of payment to include automatic Visa®/MasterCard® payment and electronic fund transfer (EFT) from a beneficiary-designated financial institution.

Disenrollment

Failure to pay monthly premiums on time will result in disenrollment which is permanent unless the Reserve component member is reactivated for a contingency operation and qualifies again for TRICARE Reserve Select.

If members disenroll from TRICARE Reserve Select, they may not re-enroll unless they are recalled to active duty and re-qualify for a new period of coverage. They must be a member of the Selected Reserve at the time of enrollment in the TRICARE Reserve Select.

Transitioning from TAMP

- For members who were enrolled in TRICARE Prime during the TAMP period, their TRICARE Prime benefit ends on the last day of the TAMP period.
  - If the Primary Care Manager (PCM) was a TRICARE network provider, the member may be able to continue seeing that provider. However, cost shares will apply for outpatient visits.
  - If the member was enrolled in TRICARE Prime at a Military Treatment Facility (MTF) PCM, the member will be able to see that provider on a space-available basis since TRICARE Prime (and assignment to a PCM) is not available under TRICARE Reserve Select.

- For Reserve component members who used TRICARE Standard or TRICARE Extra during the TAMP period, they may continue seeing the same provider under TRICARE Reserve Select.
  - To locate a TRICARE network or non-network TRICARE-authorized provider, members may visit the TRICARE provider directory at www.tricare.osd.mil/providerdirectory or call their regional contractor for assistance

When Coverage Begins

After purchasing TRICARE Reserve Select, TRS members will receive a welcome letter with TRS wallet cards for each covered member of the family.

This card contains key phone numbers and other information to assist with health care coverage. Health care providers may want to see this card before delivering care.

For Reserve component members who separated from qualifying active duty service on or after April 27, 2005, coverage begins the first day after the Reserve component member's TAMP coverage ends. Since TAMP covers 180 days, TRICARE Reserve Select starts on the 181st day.

For Reserve component members who separated from qualifying active duty service on or before April 26, 2005, coverage begins either the day the Service Agreement is executed or the first day after TAMP coverage ends, whichever is later.

Costs

- Beneficiaries are responsible for monthly premiums, annual deductibles, and cost shares.
- The government shares the cost for covered services with beneficiaries only after deductibles have been paid.

	Annual Deductible for an Individual per Fiscal Year*	**Annual Deductible for a Family per Fiscal Year***
National Guard/Reserve member whose rank is E-1 to E-4	$50	$100
National Guard/Reserve member whose rank is E-5 and above	$150	$300

* Fiscal Year is October 1 through September 30.

The beneficiary must first pay the deductible per individual or family per fiscal year. The deductible applies to outpatient care only.

Cost Shares

After the annual deductible has been met, the beneficiary will pay 15 percent for care received from a TRICARE network provider (TRICARE Extra) or 20 percent for care received from a non-network, TRICARE-authorized provider (TRICARE Standard).

Catastrophic Cap

- The catastrophic cap is the maximum out-of-pocket expense per fiscal year a beneficiary pays for TRICARE-covered services or supplies.
- The catastrophic cap is $1,000 for the member or member and their family.
  - *Note:* Monthly premium payments do not apply to the catastrophic cap.

Inpatient Costs

Civilian inpatient cost share	Greater of $25 or $13.90* per day
Civilian inpatient mental health	$20 per day

*Fiscal Year (FY) 2005 rates

If Eligible for Other TRICARE Health Coverage

If a TRS member becomes eligible for another TRICARE health benefit for any reason, the TRICARE Reserve Select coverage and premium payments are suspended. However, the end date for the original period of coverage is unchanged.

For example:
- If a member was initially activated in a contingency operation for a year and committed to four years of service in the Selected Reserve, the member qualifies for four years of TRICARE Reserve Select.
- Then two years after starting TRICARE Reserve Select coverage, the member is reactivated for 180 days.
  - The member becomes eligible for 180 days of TRICARE coverage (90 days of early eligibility and 90 days while on active duty).
  - The member's original TRICARE Reserve Select benefit continues to run, but the member and his or her family are now covered by active duty military health benefits followed by 180 days of TAMP coverage upon release.
  - Following the termination of TAMP, the member's TRICARE Reserve Select coverage resumes until the original termination date, leaving the member with one year of coverage remaining.

While covered under active duty health care benefits and TAMP, the member will not be responsible for TRICARE Reserve Select premium payments. The member may establish a new period of coverage by executing a new Service Agreement with the Selected Reserve.

Programs not Available with TRICARE Reserve Select

The following programs are not available under TRICARE Reserve Select:

- TRICARE Reserve Family Demonstration Program (and its successor program that includes waiver of deductibles and higher payments to providers)
- The Program for Persons with Disabilities
- Uniformed Services Family Health Plan
- TRICARE Prime
- TRICARE Prime Remote
- TRICARE Prime Remote for Active Duty Family Members
- TRICARE Overseas Program Prime
- TRICARE Global Remote Overseas
- TRICARE Prime in Puerto Rico

TRO-North

Health Net Federal Services, Inc.
TRICARE Reserve Select Enrollment
PO Box 870162
Surfside Beach, SC 29587-9762
(800) 555-2605
www.hnfs.net/bene/home

TRO-South

Humana Military Healthcare Services, Inc.
PO Box 105389
Atlanta, GA 30348-5389
(800) 444-5445
www.humana-military.com

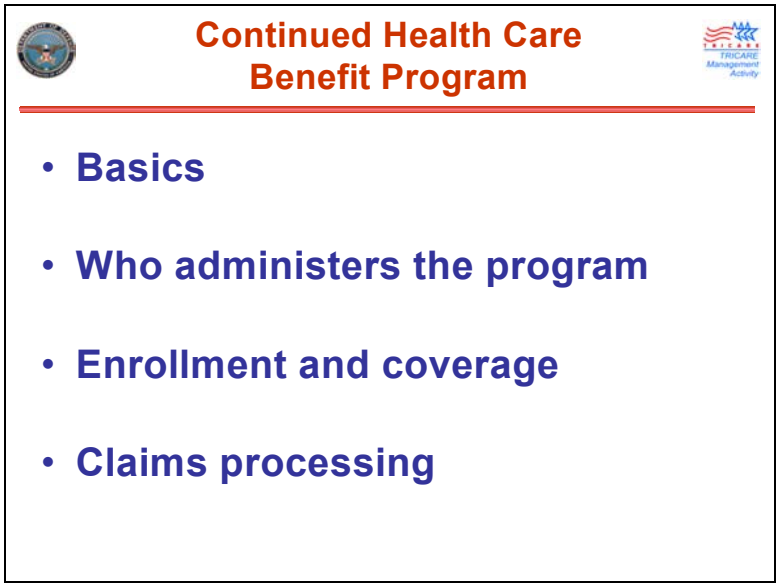
TRO-West

TriWest Healthcare Alliance
PO Box 42048
Phoenix, AZ 85080-2048
888-TRIWEST
(888) 874-9378
www.triwest.com

TRICARE Overseas

Humana Military Healthcare Services, Inc.
PO Box 105838
Atlanta, GA 30348-5838
(800) 444-5445
www.humana-military.com

Continued Health Care Benefit Program (CHCBP)



- The Continued Health Care Benefit Program (CHCBP) is a congressionally mandated program that began on October 1, 1994, as a means to protect eligible Service members and their families in the interim between military health benefits and civilian health care.
- CHCBP is a premium-based health care program that provides medical coverage similar to TRICARE Standard for a specific period (18 to 36 months) for the following:
  - Former Service members and their families voluntarily or involuntarily separated under other than adverse conditions
    - Including Reserve component members ordered to active duty for more than 30 consecutive days in support of a contingency operation
    - Those who serve on active duty for more than 30 consecutive days but were not ordered to active duty in support of a contingency are not eligible for transitional health care benefits.
  - Certain unremarried former spouses
  - Children who lose military coverage due to age or marriage
- Eligible persons must enroll in the CHCBP within 60 days after separation from active duty or loss of eligibility for military health care and pay the quarterly premiums.

- Reserve Component Members
  - After the TAMP eligibility expires, members and eligible family members may choose to enroll in CHCBP.
  - Eligible persons must enroll in the CHCBP within 60 days after separation from active duty or loss of eligibility for military health care under TAMP.
- Voluntary Separation Benefits
  - Service members who voluntarily separate under the Special Separation Benefit (SSB) or the Voluntary Separation Incentive (VSI) options will be entitled to all of the benefits provided for involuntarily separated members.
  - Members who choose the SSB or VSI options (and their families) may continue their health benefits by enrolling in CHCBP.

CHCBP Basics

- Eligibility for CHCBP is determined through the military personnel offices.
- Continuous coverage
- Acts as a "bridge" between military health benefits and civilian health care
  - Provides temporary health care coverage following loss of military benefits
  - Uses existing TRICARE providers and follows most of the rules and procedures of TRICARE Standard
- Preexisting condition coverage
  - May allow coverage for preexisting conditions often not covered by a new employer's benefit plan
- Benefits
  - Comparable to the TRICARE Standard benefit that covers a majority of medical conditions
  - However, coverage for some types of treatment may be limited
- Benefits not covered are listed in the TRICARE Handbook. (See What's Not Covered appendix in the Participant's Guide.)
- Contact Humana Military Healthcare Services, (Humana) when in doubt.

Who Administers the Program?

- CHCBP is a Department of Defense (DoD) sponsored program administered by Humana
- Humana is responsible for
  - Verification of health plan eligibility
  - Collection of health plan premiums
  - Enrollment of beneficiaries into CHCBP
  - Disenrollment if eligibility expires or premiums are not paid

- Humana can be contacted in writing, by phone, or via its Web site:
  Humana Military Healthcare Services
  Attn: CHCBP
  P.O. Box 740072
  Louisville, KY 40201
  1-800-444-5445, option 4
  www.humana-military.com

Enrollment and Coverage

- Eligible beneficiaries must enroll in CHCBP within 60 days following the loss of entitlement to Military Health System benefits.
  - Exception, TRICARE Reserve Select beneficiaries must enroll in CHCBP within 30 days after loss of TRS eligibility.
- To enroll, beneficiaries are required to submit the following:
  - A completed CHCBP enrollment application form (DD Form 2837)
  - Required documentation, as indicated on the enrollment form, such as follows:
    - DD 214, Certificate of Release or Discharge from Active Duty
    - Final divorce decree, if applicable
    - DD 1173, Uniformed Services Identification Card
  - Additional information and documentation to confirm an applicant's eligibility for CHCBP
  - A premium payment for the first 90 days of health coverage

A premium payment for the first 90 days of health coverage
- The current premium rates are as follows:
  - $933 per quarter for individuals
  - $1,996 per quarter for families
- Humana will bill enrollees for subsequent quarterly premiums through their period of eligibility once they are enrolled.

- The program uses existing TRICARE providers and follows most of the rules and procedures of the TRICARE Standard program:
  - Enrollees are eligible for reduced costs associated with the TRICARE Extra program by using civilian TRICARE network providers.
  - Enrollees are not eligible for TRICARE Prime.
  - Depending on the beneficiary category, CHCBP coverage is limited to either 18 or 36 months. Eligibility periods are as follows:
    - Separating Service members and their families—18 months
    - Unremarried former spouses, emancipated children, unremarried children by adoption or legal custody (in some cases, unremarried former spouses may continue coverage beyond 36 months if they meet certain criteria)—36 months

Note: Enrollees may not elect the effective date of coverage under CHCBP. Coverage is effective on the day after enrollees lose their military health care benefits.

CHCBP Claims Processing

- Claims are submitted to the claims processor responsible for the TRICARE region in which the beneficiary lives.
- Enrollees may request their provider file medical claims on their behalf.
  - TRICARE Extra (network) providers will file for enrollees.
- If the provider does not file the claim, the enrollee has to do so.
  - This is typical for enrollees using TRICARE Standard.
  - The enrollee submits the claim form, DD Form 2642, found at this Web address: www.tricare.osd.mil/claims/Dd2642.pdf. (The enrollee can also get a copy of the form by contacting Humana or getting one from the nearest TRICARE Service Center along with the provider's bill.)
  - The claim form needs to be sent to the enrollee's appropriate regional claims processor (list below) with a copy of the enrollee's CHCBP enrollment card attached.
  - Enrollees should contact the claims processor directly if any problems exist.

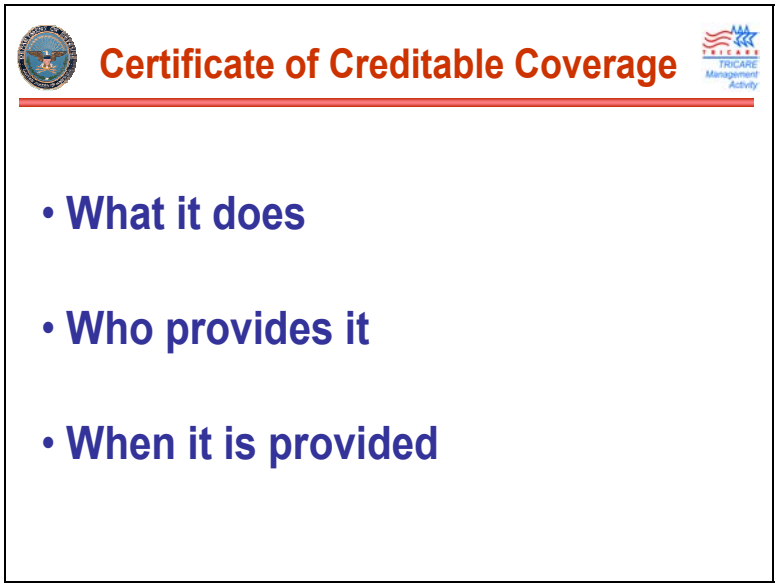
West
Claims Contractor: **WPS**
Claims Mailing Address: WPS/West Region Claims
P.O. Box 77028 Madison, WI 53707-7028
Toll-free Phone for Claims: **1-888-TRIWEST (888) 874-9378**
Claims Processor's Web Site: www.tricare4u.com

North
Claims Contractor: **PGBA**
Claims Mailing Address: Health Net Federal Services, Inc., c/o PGBA, LLC/TRICARE, P.O. Box 870140, Surfside Beach, SC 29587-9740
Toll-free Phone for Claims: **(800) 930-2929**
Claims Processor's Web Site: www.mytricare.com

South
Claims Contractor: **PGBA**
Claims Mailing Address: TRICARE South Region, Claims Department, P.O. Box 7031, Camden, SC 29020-7031
Toll-free Phone for Claims: **(800) 403-3950**
Claims Processor's Web Site: www.humana-military.com

For more information:
- Go to the CHCBP page on the TRICARE Web site at www.tricare.osd.mil/chcbp/default.cfm, or
- Call Humana at (888) 444-5445 or visit its Web site at www.humana-military.com/chcbp/main.htm

What is a Certificate of Credible Coverage?



- A Certificate of Creditable Coverage serves as evidence of prior health care coverage.
- It can be used to reduce or eliminate medical preexisting condition waiting periods found under a civilian employer's health plan.
  - A preexisting condition could be defined as a condition for which medical advice, diagnosis, care, or treatment is recommended or received within a certain period before an individual becomes eligible under another group health plan.
  - Basically what this means is that if a sponsor or family member has asthma, the new health plan may not cover any claims for asthma for 6 months, unless the sponsor or family member can show previous health coverage for the condition.
- The MHS is automatically issuing a Certificate of Credible Coverage to any former Uniformed Services sponsor or family member who loses eligibility for health care benefits under TRICARE.
  - Eligibility for TRICARE may end as a result of:
    - A sponsor's separation from active duty status
    - Divorce
    - Demobilization if the sponsor is a member of the National Guard or Reserves
    - Or a dependent child reaching age 21 (23 for full-time students).

- The Defense Manpower Data Center Support Office (DSO), as custodian of DEERS, will mail a Certificate for the sponsor or family member within 5 to 10 days after eligibility has been lost.
  - As long as a current address is on file in DEERS, beneficiaries may expect to receive the Certificate within 30 days.
  - Note, retirees and eligible spouses will not automatically get Certificates of Creditable Coverage upon retirement since they retain TRICARE coverage for life.
  - Eligible retirees or those who may have lost their certificate may still request a certificate in writing, which will be delivered through the mail to the sponsor or family member free of charge.
  - Certificates cannot be requested from DSO by phone.
  - Beneficiaries needing to expedite receipt of a Certificate may fax the request to DSO at (831) 655-8317 or mail to Defense Manpower Data Center Support Office (DSO), Attn: Certificate of Credible Coverage, 400 Gigling Road, Seaside, CA 93955-6771.
  - The request must include:
    - Sponsor's name and Social Security Number
    - Name of person for whom the Certificate is requested
    - Reason for the request
    - Name and address to whom and where the Certificate should be sent
    - Signature of the requester
  - Beneficiaries who have questions regarding this certificate should call the DSO at 1-800-538-9552 (TTY/TDD: 1-866-363-2883).

TRICARE - Military Managed Health Care Program
(formerly CHAMPUS)

Certificate of Creditable Coverage

IMPORTANT. This certificate provides evidence of your prior health care coverage under one of the TRICARE administered programs. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll (also known as pre-existing conditions). This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within a certain time period (often six months to one year) prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____

2. Participant (Sponsor) name: _____

3. Participant (Sponsor) Identification Number: _____

4. Names of individual(s) to whom this certificate applies:

   Participant: _____ Dependent: _____
   Dependent: _____ Dependent: _____
   Dependent: _____ Dependent: _____

5. All questions concerning this certificate should be directed to:
   Defense Manpower Data Center (DMDC) Support Office
   400 Gigling Road
   Seaside, CA 93955-6771
   For further information, call: 1-800-538-9552
   TTY/TDD: 1-866-363-2883

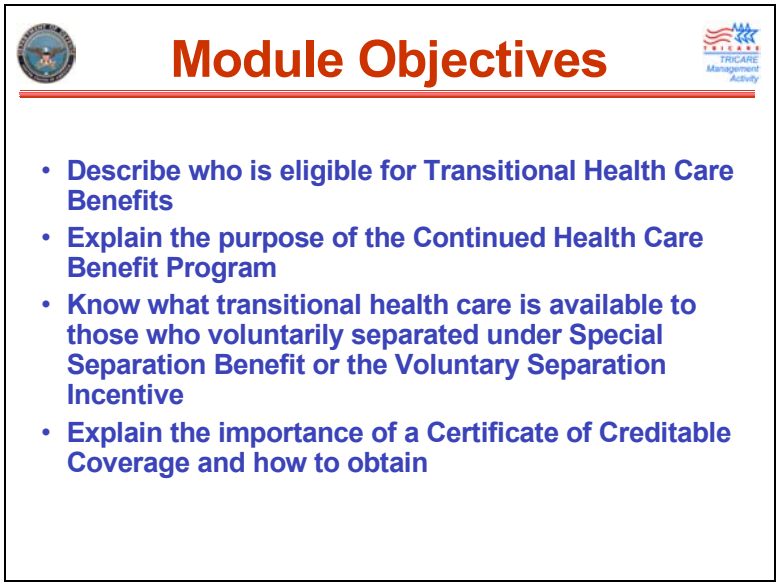
6. If the individual(s) identified in Line 4 above has/have at least 18 months of creditable coverage, check here ____ and skip Line 7. (Does not include any periods of coverage that occurred prior to a break in coverage of more than 63 days.)

7. Date coverage began: _____

8. Date coverage ended: _____ (or check if coverage continuing as of date of this certificate): _____

NOTE: Separate certificates will be furnished if information is not identical for the participant and each dependent.

Summary


Module Objectives
• Describe who is eligible for Transitional Health Care Benefits
• Explain the purpose of the Continued Health Care Benefit Program
• Know what transitional health care is available to those who voluntarily separated under Special Separation Benefit or the Voluntary Separation Incentive
• Explain the importance of a Certificate of Creditable Coverage and how to obtain